

# Exhibit G



# Corpus Christi Police Department

321 John Sartain St.  
Corpus Christi, TX 78401  
(361) 886-2840

## CRIMINAL TRESPASS WARNING

YOU ARE HEREBY PROHIBITED FROM ENTERING, REMAINING UPON, OR RE-ENTERING THE PROPERTY OR PROPERTIES LISTED BELOW. ANY VIOLATION OF THIS WARNING NOTICE WILL BE CONSIDERED A CRIMINAL TRESPASS PROHIBITED BY SECTION 30.05 OF THE TEXAS PENAL CODE AND WILL SUBJECT YOU TO ARREST AND CRIMINAL CHARGES. UPON CONVICTION YOU MAY BE FINED UP TO \$2,000 AND SENTENCED TO JAIL FOR UP TO 180 DAYS. PLEASE ACT ACCORDINGLY.

LOCATION: 613 Elizabeth st ☐ ALL LOCATIONS

DATE WARNED: 12-27-16 TIME: 1253

WARNING ISSUED TO: Green, Billy Theron

ADDRESS: 13944 [REDACTED] st 7778416

RACE: W SEX: M HAIR: BRO EYES: BRO HEIGHT: [REDACTED] WEIGHT: [REDACTED]

DOB: [REDACTED] SIGNATURE: [Signature]

WARNING ISSUED BY: Donal Martinez

BUSINESS REPRESENTATIVE: Spina Shurtlee

AUTHORITY: Spina Shurtlee TELEPHONE #: \_\_\_\_\_

SIGNATURE: [Signature] CCPD CASE #: \_\_\_\_\_

OFFICER AT SCENE: Brian Coma PAYROLL ID #: [REDACTED]

OFFICER AT SCENE: \_\_\_\_\_ PAYROLL ID #: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

# Exhibit H

EEOC Form 5 (11/09)

<b>CHARGE OF DISCRIMINATION</b> <small>This form is affected by the Privacy Act of 1974. See enclosed Privacy Act Statement and other information before completing this form.</small>		Charge Presented To: <input type="checkbox"/> FEPA <input checked="" type="checkbox"/> EEOC		Agency(ies) Charge No(s): <b>451-2018-00897</b>
<b>Texas Workforce Commission Civil Rights Division</b> and EEOC <small>State or local Agency, if any</small>				
Name (indicate Mr., Ms., Mrs.) <b>Mr. Billy T Green</b>		Home Phone [REDACTED]		Year of Birth <b>1964</b>
Street Address <b>[REDACTED] St., CORPUS, TX 78418</b>				
City, State and ZIP Code				
Named is the Employer, Labor Organization, Employment Agency, Apprenticeship Committee, or State or Local Government Agency That I Believe Discriminated Against Me or Others. (If more than two, list under PARTICULARS below.)				
Name <b>CHRISTUS HEALTH</b>		No. Employees, Members <b>501+</b>		Phone No. <b>469-282-2330</b>
Street Address <b>919 Hidden Ridge, IRVING, TX 75038</b>				
City, State and ZIP Code				
Name [REDACTED]		No. Employees, Members [REDACTED]		Phone No. [REDACTED]
Street Address [REDACTED]				
City, State and ZIP Code				
DISCRIMINATION BASED ON (Check appropriate box(es).) <input type="checkbox"/> RACE <input type="checkbox"/> COLOR <input type="checkbox"/> SEX <input type="checkbox"/> RELIGION <input type="checkbox"/> NATIONAL ORIGIN <input type="checkbox"/> RETALIATION <input type="checkbox"/> AGE <input checked="" type="checkbox"/> DISABILITY <input type="checkbox"/> GENETIC INFORMATION <input type="checkbox"/> OTHER (Specify)				DATE(S) DISCRIMINATION TOOK PLACE Earliest    Latest <b>06-01-2016    12-15-2016</b> <input checked="" type="checkbox"/> CONTINUING ACTION
THE PARTICULARS ARE (If additional paper is needed, attach extra sheet(s)). <p>I was employed with Christus Health from on or about June 2013 to on or about December 15, 2016, as a Pharmacist Informaticist. I was discharged on December 15, 2016, and I believe it was based on my disability.</p> <p>In March 2016, June 2016, and again in December 2016, I asked my supervisor, Erica Chapa, Department Supervisor, for an ergonomic chair based on my disability. Ms. Chapa suggested I swap my chair out with other chairs available in the department. The other chairs in the department were also not suitable for my disability, and Ms. Chapa made no other effort to provide me an accommodation. I also requested to work remotely based on my disability, however I was again denied an accommodation.</p> <p>I was ultimately discharged on or about December 15, 2016, after I was written up three times for issues related to my accommodation needs.</p> <p>I believe I was discriminated against based on my disability, in violation of the Americans with Disabilities Act of 1990, as amended.</p>				
I want this charge filed with both the EEOC and the State or local Agency, if any. I will advise the agencies if I change my address or phone number and I will cooperate fully with them in the processing of my charge in accordance with their procedures.		NOTARY - When necessary for State and Local Agency Requirements		
I declare under penalty of perjury that the above is true and correct.		I swear or affirm that I have read the above charge and that it is true to the best of my knowledge, information and belief. SIGNATURE OF COMPLAINANT		
Digitally signed by Billy Green on 01-02-2018 05:46 PM EST		SUBSCRIBED AND SWORN TO BEFORE ME THIS DATE (month, day, year)		

BG000213

CP Enclosure with EEOC Form 5 (11/09)

**PRIVACY ACT STATEMENT:** Under the Privacy Act of 1974, Pub. Law 93-579, authority to request personal data and its uses are:

1. **FORM NUMBER/TITLE/DATE.** EEOC Form 5, Charge of Discrimination (11/09).
2. **AUTHORITY.** 42 U.S.C. 2000e-5(b), 29 U.S.C. 211, 29 U.S.C. 626, 42 U.S.C. 12117, 42 U.S.C. 2000ff-6.
3. **PRINCIPAL PURPOSES.** The purposes of a charge, taken on this form or otherwise reduced to writing (whether later recorded on this form or not) are, as applicable under the EEOC anti-discrimination statutes (EEOC statutes), to preserve private suit rights under the EEOC statutes, to invoke the EEOC's jurisdiction and, where dual-filing or referral arrangements exist, to begin state or local proceedings.
4. **ROUTINE USES.** This form is used to provide facts that may establish the existence of matters covered by the EEOC statutes (and as applicable, other federal, state or local laws). Information given will be used by staff to guide its mediation and investigation efforts and, as applicable, to determine, conciliate and litigate claims of unlawful discrimination. This form may be presented to or disclosed to other federal, state or local agencies as appropriate or necessary in carrying out EEOC's functions. A copy of this charge will ordinarily be sent to the respondent organization against which the charge is made.
5. **WHETHER DISCLOSURE IS MANDATORY; EFFECT OF NOT GIVING INFORMATION.** Charges must be reduced to writing and should identify the charging and responding parties and the actions or policies complained of. Without a written charge, EEOC will ordinarily not act on the complaint. Charges under Title VII, the ADA or GINA must be sworn to or affirmed (either by using this form or by presenting a notarized statement or unsworn declaration under penalty of perjury); charges under the ADEA should ordinarily be signed. Charges may be clarified or amplified later by amendment. It is not mandatory that this form be used to make a charge.

#### NOTICE OF RIGHT TO REQUEST SUBSTANTIAL WEIGHT REVIEW

Charges filed at a state or local Fair Employment Practices Agency (FEPA) that dual-files charges with EEOC will ordinarily be handled first by the FEPA. Some charges filed at EEOC may also be first handled by a FEPA under worksharing agreements. You will be told which agency will handle your charge. When the FEPA is the first to handle the charge, it will notify you of its final resolution of the matter. Then, if you wish EEOC to give Substantial Weight Review to the FEPA's final findings, you must ask us in writing to do so within 15 days of your receipt of its findings. Otherwise, we will ordinarily adopt the FEPA's finding and close our file on the charge.

#### NOTICE OF NON-RETALIATION REQUIREMENTS

Please **notify** EEOC or the state or local agency where you filed your charge **if retaliation is taken against you or others** who oppose discrimination or cooperate in any investigation or lawsuit concerning this charge. Under Section 704(a) of Title VII, Section 4(d) of the ADEA, Section 503(a) of the ADA and Section 207(f) of GINA, it is unlawful for an *employer* to discriminate against present or former employees or job applicants, for an *employment agency* to discriminate against anyone, or for a *union* to discriminate against its members or membership applicants, because they have opposed any practice made unlawful by the statutes, or because they have made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under the laws. The Equal Pay Act has similar provisions and Section 503(b) of the ADA prohibits coercion, intimidation, threats or interference with anyone for exercising or enjoying, or aiding or encouraging others in their exercise or enjoyment of, rights under the Act.

# Exhibit I

EEOC Form 161 (11/16)

## U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

## DISMISSAL AND NOTICE OF RIGHTS

To: **Billy T. Green, Jr.**  
 [REDACTED]  
 Corpus Christi, TX 78418

From: **San Antonio Field Office**  
**5410 Fredericksburg Rd**  
**Suite 200**  
**San Antonio, TX 78229**

☐

On behalf of person(s) aggrieved whose identity is  
**CONFIDENTIAL (29 CFR §1601.7(a))**

EEOC Charge No.	EEOC Representative	Telephone No.
<b>451-2018-00897</b>	<b>Angelica Davila, Investigator</b>	<b>(210) 281-2519</b>

## THE EEOC IS CLOSING ITS FILE ON THIS CHARGE FOR THE FOLLOWING REASON:

☐

The facts alleged in the charge fail to state a claim under any of the statutes enforced by the EEOC.

☐

Your allegations did not involve a disability as defined by the Americans With Disabilities Act.

☐

The Respondent employs less than the required number of employees or is not otherwise covered by the statutes.

☒

Your charge was not timely filed with EEOC; in other words, you waited too long after the date(s) of the alleged discrimination to file your charge

☐

The EEOC issues the following determination: Based upon its investigation, the EEOC is unable to conclude that the information obtained establishes violations of the statutes. This does not certify that the respondent is in compliance with the statutes. No finding is made as to any other issues that might be construed as having been raised by this charge.

☐

The EEOC has adopted the findings of the state or local fair employment practices agency that investigated this charge.

☐

Other (briefly state)

## - NOTICE OF SUIT RIGHTS -

(See the additional information attached to this form.)

**Title VII, the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, or the Age Discrimination in Employment Act:** This will be the only notice of dismissal and of your right to sue that we will send you. You may file a lawsuit against the respondent(s) under federal law based on this charge in federal or state court. Your lawsuit must be filed **WITHIN 90 DAYS** of your receipt of this notice; or your right to sue based on this charge will be lost. (The time limit for filing suit based on a claim under state law may be different.)

**Equal Pay Act (EPA):** EPA suits must be filed in federal or state court within 2 years (3 years for willful violations) of the alleged EPA underpayment. This means that backpay due for any violations that occurred **more than 2 years (3 years)** before you file suit may not be collectible.

On behalf of the Commission

*Travis G. Hicks*

Travis G. Hicks,  
Director

*1/10/2018*

(Date Mailed)

Enclosures(s)

cc:

Kimberly K. Webb  
 Deputy General Counsel  
 CHRISTUS HEALTH  
 919 Hidden Ridge  
 Irving, TX 75038

BG000215

# Exhibit J



**IN THE UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF TEXAS  
CORPUS CHRISTI DIVISION**

**BILLY T. GREEN,**

**Plaintiff,**

**v.**

**CHRISTUS SPOHN HEALTH SYSTEM  
CORPORATION, d/b/a CHRISTUS  
SPOHN HOSPITAL CORPUS CHRISTI,**

**Defendant.**

**CIVIL ACTION NO. 2:18-CV-00064**

**TEXAS BUSINESS RECORDS AFFIDAVIT**

**STATE OF NORTH CAROLINA**

**COUNTY OF MECKLENBURG**

BEFORE ME, the undersigned authority, on this day personally appeared Peter Miller who,  
being duly sworn, deposed as follows:

“My name is Peter Miller. I am over eighteen (18) years of age, of sound mind, capable of making this Affidavit and personally acquainted with the facts herein stated. I am Director of STD/Absence Claims with Lincoln Financial Group f/k/a Liberty Life Assurance Company of Boston (“Liberty”). Effective June 16, 2013, Liberty entered into an Administrative Services Only Agreement with CHRISTUS Health, under which it administers certain benefit plans for employees of CHRISTUS Health, including Short Term Disability and Family and Medical Leave (“Leave Administration”).

I am familiar with the records maintained by Liberty in connection with its Leave Administration for CHRISTUS Health, and I am a custodian of those records. These records are

kept by Liberty in the regular course of its business of Leave Administration for CHRISTUS Health.

Liberty conducted a thorough search of its files and records for all records pertaining to Billy T. Green, SSN XXX-XX-XXXX. True, correct and complete copies of all documents relating to Mr. Green identified through this search are being produced with this Affidavit, Bates labeled L0001-L0041.

These documents are kept by Liberty in the regular course of its business, and the records were made at or near the time of the events depicted or described therein. The records designated herein are the original or exact duplicates of the originals."



PETER MILLER (Custodian of Records)  
Director of STD/Absence Claims  
Lincoln Financial Group f/k/a Liberty Life  
Assurance Company of Boston

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority, on the 11<sup>th</sup> day of March, 2019.



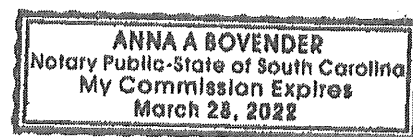
Notary Public, State of Kentucky South Carolina

(SEAL)



Printed Name

My commission expires: 3-28-22



**Note Report**

<a href="#">Report</a>	<a href="#">Clear</a>	<a href="#">Print</a>	<a href="#">Help</a>
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[AS Accom](#) [AS Event](#) [Add Note](#) [Appeal](#) [Claim](#) [Coord Claim Note](#) [Correspond](#) [Doc List](#) [Employee](#) [Leave](#) [Life Claim](#) [Lve Addtl Info](#)  
[Lve Correspondence](#) [Lve Program](#) [Lve Work Sched](#) [Medical](#) [Medical History](#) [Note](#) [SPELL Letters](#) [Scheduled Pmt](#) [Task Print](#) [Task Rpt](#)  
[Tasks](#)

Claim	Primary Sort Order	Sec
* Claim/Event/Leave Number <input type="text" value="3908269"/>	Note Type	●
Accommodation Number <input type="text"/>	Note Number	
Note type: <input type="text"/>	● Note Date/Time	
	Accm. No.	

**02/19/2019 11:40 AM - PHONE Note 2**

Claim/Event/Leave: 3908269

NoteSubject : Called EE

Other Subject : RC

Text: [02/19/2019 - HITSSELBERGER, DANIEL]DCM RC, NO ANSWER, "VERIZON CUSTOMER UNAVAILABLE". DCM UNABLE TO LEAVE VM

**02/19/2019 11:38 AM - PHONE Note 1**

Claim/Event/Leave: 3908269

NoteSubject : EE Called

Other Subject : VM 2/15

Text: [02/19/2019 - HITSSELBERGER, DANIEL]EE CALLED LEFT VM ADV NEED PPWK FROM CLAIM SENT, DCM WILL RC

**02/15/2019 12:00 PM - LEAVE Note 1**

Claim/Event/Leave: 3908269

NoteSubject : FMLA

Other Subject :

Text: [02/15/2019 - MELTON, CHERYL] EE REQUESTED A COPY OF HIS DENIAL LETTER...EMAILED EE PER EE REQUEST..TRANSFERRED TO STD FOR ASSISTANCE WITH STD CLAIM

**12/04/2017 11:27 AM - CLAIM Note 8**

Claim/Event/Leave: 3908269

NoteSubject : Other

Other Subject : AUTHOR FORM

Text: [12/04/2017 - HITSSELBERGER, DANIEL]ADDED TO DOC LIST. NO ACTION NEEDED, CLAIM DENIED, EE TERMINATED ON 12/16/16

**11/30/2017 8:39 AM - CLAIM Note 7**

Claim/Event/Leave: 3908269

NoteSubject : LTR to EE

Other Subject : DENIAL

Text: [11/30/2017 - HITSSELBERGER, DANIEL]LETTER SENT EE TERMINATED 12/16/16

**11/29/2017 12:52 PM - CLAIM Note 6**

Claim/Event/Leave: 3908269

NoteSubject : FMLA

Other Subject : LEAVE END

Text: THIS LEAVE WAS DENIED FOR EMPLOYMENT TERMINATED

**11/29/2017 9:59 AM - CLAIM Note 5**

Claim/Event/Leave: 3908269

NoteSubject : VOID

Other Subject : DATA ERROR

Text: [11/29/2017 - HITSSELBERGER, DANIEL]EE WAS TERMINATED ON 12/16/16. DCM WILL VOID FOR DATA ERROR

**11/29/2017 9:58 AM - CLAIM Note 4**

Claim/Event/Leave: 3908269

NoteSubject : Other

Other Subject : TERMINATION

Text: [11/29/2017 - HITSSELBERGER, DANIEL]GOOD MORNING; ASSOCIATE BILLY T GREEN HAS BEEN TERMED 12/16/2016. I DID NOT COMPLETE ELIGIBILITY FORM. THANK YOU, YVONNE \*\*\*\*FROM ER ADDED TO DOC LIST

**11/29/2017 9:50 AM - CLAIM Note 3**

Claim/Event/Leave: 3908269

NoteSubject : Initial Entry

NoteSubject : initial entry

Other Subject :

Text: [11/29/2017 - BLANCHETTE, JACOB]RCVD NOTICE THAT EE WAS TERMINATED 12/16/2016[11/29/2017 - BLANCHETTE, JACOB]CLAIM ASSIGNED IN PROCESS DUE TO EE NOT FOUND IN ELIG -- PLEASE VERIFY[11/29/2017 - BLANCHETTE, JACOB] PLEASE VERIFY DOH -- ENTERED DEFAULT DATE

**11/27/2017 6:28 PM - CLAIM Note 1**

Claim/Event/Leave: 3908269

NoteSubject : Telephonic Intake

Other Subject : REPORTED CLAIM NOTE

Text: G WEESNER HE DID NOT WANT TO TELL ME THE DISABILITIES HE HAD HIS INFO DID NOT PULL UP WHEN I ENTERED THE SOCIAL ERTW UNKNOWN AS OF RIGHT NOW

**11/27/2017 6:28 PM - CLAIM Note 2**

Claim/Event/Leave: 3908269

NoteSubject : Telephonic Intake

Other Subject : MEDICAL CONDITION

Text: THREE DIFFERENT DISABILITIES

## Claim Coversheet Report

Find Clear Print Save New Help

Admin Notes Claim Class Correspond Doc List Medical SPELL Letters

Claim Number 3908269 Claim Last Updated 11/29/2017 Printed On 2/26/2019

## Claimant Information

Name BILLY GREEN SSN XXX-XX- Birth Date  
 Address Salary Amount \$0.01 Mode  
 Date of Hire 01/13/1965  
 Last Work Date 12/16/2016  
 SOPERTON, GA 30457-0000 Federal Tax State Tax  
 Phone Phys Demands Sedentary  
 Job Desc

Claim Status Denied Status Reason Contractual Denial/Other Received Date 11/27/2017  
 Disability Date 12/17/2016 Close Date 12/17/2016 Reopen Date  
 Sick Days Left Max Ben Date RTW FT / PT  
 Ben Begin Date Apprv Thru Date Gross Ben \$

Diagnosis 1 Code/Desc 000 UNKNOWN CONDITION OR PROCEDURE

Diagnosis 2 Code/Desc

## Policyholder Information

Customer ID 09 - 460617 CHRISTUS HEALTH  
 Subsidiary TERM TERMED EMPLOYEES  
 Location TERMDASO ASO TERMED EMPLOYEES

Symb Numeral Product STD Funding Bank Calcs Cntr Eff

Class

Waiting Period: New/Mode-Current/Mode 0 0 Days In WRKWK Pre-X

Elimination Period: Days/Type 0 Sickness COLA: Mode/Duration

Successive Period: Period/Mode SS Integration: Type/Value

Partial Disability Type/Pct Survivor Ben Months/Wait Period

Non-Verifiable Symptoms Limit Own Occupation Definition Limit M/N Limit

Benefit % Max Benefit \$ Min Benefit \$ Employer Contr % Subro Ind

## Selected Benefits

Symbol	Numeral	Product Type	Class	Eligibility Date

Additional Information:

Liberty Life Assurance Company of Boston  
Group Benefits Disability Claims  
P.O. Box 7207  
London, KY 40742-7207

MR. BILLY GREEN

[REDACTED]  
SOPERTON GA 30457

L000019



Liberty Life Assurance Company of Boston  
Group Benefits Disability Claims  
P.O. Box 7207  
London, KY 40742-7207  
Phone No.: (800) 291-0112  
Secure Fax No.: (603) 334-7120

December 1, 2017

Mr. Billy Green  
[REDACTED]

SOPERTON, GA 30457

RE: Short Term Disability (STD) Benefits  
Christus Health  
Claim #: 3908269

Dear Mr. Billy Green:

Liberty Life Assurance Company of Boston ("Liberty") is responsible for managing claims for Short Term Disability (STD) benefits under Christus Health's Group Disability Plan. We are writing in reference to your claim for STD benefits under the Plan.

Based on the information received, your claim has been denied and no benefits are payable.

The Plan contains the following provision regarding termination of coverage:

***WHEN DO STD BENEFIT PAYMENTS END?***

*An STD Program Participant will not be (or will no longer be) eligible to receive STD Benefits on the earliest to occur of the dates set forth below, and, if an STD Program Participant is receiving STD Benefits on account of a Disability on such date, payment of those STD Benefits will stop, or, if an STD Program Participant is scheduled to begin receiving (or continue to receive) STD Benefits on such date, those STD Benefits will not be paid:*

*The date the STD Program Participant terminates employment with CHRISTUS.*

Since your date of disability is December 17, 2016 and you were terminated on December 16, 2016, we are unable to approve your claim.

*Please be advised that you may still be eligible for Long Term Disability Benefits. To determine if you are eligible for these benefits or with questions on next steps, please contact your Case Manager at Liberty Mutual. Liberty Mutual will provide you a time frame that you will need to follow up to file your claim for Long Term Disability benefits if you remain disabled.*

This claim determination reflects an evaluation of the claim facts and the Plan provisions. We



reserve the right to make a determination on any additional information that may be submitted.

Under the Employee Retirement Income Security Act of 1974 (ERISA), you may request a review of this denial by writing to the address below:

The Liberty Life Assurance Company of Boston  
Disability Claims  
P.O. Box 7207  
London, KY 40742-7207

The written request for review must be sent within 180 days from the date of this letter and state the reasons you feel your claim should not have been denied. In your request for review please include the following documentation:

Proof that your employment was not terminated on December 16, 2016.

You should also provide any additional information that you feel will support your claim.

You may request to review pertinent claim file documents upon which the denial of benefits was based. If Liberty Life does not receive your written request for review within 180 days from the date of this notice, our claim decision will be final, your file will remain closed, and no further review will be conducted.

Under normal circumstances, you will be notified of the final decision within 45 days from the date your request is received.

If special circumstances cause a delay in our decision, you will be notified of the final decision no later than 90 days from the date your request is received.

Nothing in this letter should be construed as a waiver of any rights and defenses under the above captioned Plan, and all of these rights and defenses are reserved to the company, whether or not they are specifically mentioned herein.

If you have any questions regarding this matter, please contact me.

Sincerely,

Daniel Hitselberger  
Disabil Claims Case Mgr I  
Phone No.: (800) 291-0112 Ext. 13977  
Secure Fax No.: (603) 334-7120



n0285007

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**From:** Blanchette, Jacob  
**Sent:** Wednesday, November 29, 2017 9:54:07 AM  
**To:** Hitselberger, Daniel  
**Subject:** FW: Liberty Mutual Eligibility Forms – CORP Region (11.28.2017)  
**Attachments:** image001.jpg

Good morning,

Please advise below.

Thank you

~Jake

Jacob Blanchette

Screening and Creation Unity/Liberty Mutual Benefit Claims – Claims Support

Liberty Life Assurance Company of Boston

100 Liberty Way Dover, NH 03820

Seat Number: 03F-R672

[Jacob.Blanchette@LibertyMutual.com](mailto:Jacob.Blanchette@LibertyMutual.com)

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L000022

**From:** Green, Joscelin  
**Sent:** Wednesday, November 29, 2017 9:23 AM  
**To:** Blanchette, Jacob <Jacob.Blanchette@LibertyMutual.com>  
**Subject:** FW: Liberty Mutual Eligibility Forms – CORP Region (11.28.2017)  
**Importance:** High

Good morning Jacob,

Christus has advised that Billy Green (claim # 3908269) has been terminated. Pleased see thread for additional information.

Thanks!

Kind regards,

**Joscelin M. Green, AIC**

SBU System Support Analyst II

Liberty Mutual Benefits Technology Services

Liberty Mutual Insurance

P.O. Box 7208, London, KY 40742-7208

Direct Dial: 704-759-7812

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**From:** Herrera, Yvonne [<mailto:yvonne.herrera2@christushealth.org>]  
**Sent:** Wednesday, November 29, 2017 9:10 AM

**L000023**

**To:** Green, Joscelin <[JOSCELIN.GREEN@LibertyMutual.com](mailto:JOSCELIN.GREEN@LibertyMutual.com)>;  
!\_CH.Corp.HR.STDLeave <[CH.Corp.HR.STDLeave@christushealth.org](mailto:CH.Corp.HR.STDLeave@christushealth.org)>  
**Cc:** Horton, Terena D. <[terena.horton@christushealth.org](mailto:terena.horton@christushealth.org)>; Burns, Diedra  
<[diedra.burns@christushealth.org](mailto:diedra.burns@christushealth.org)>; !\_CH.Corp.HR.STDLeave  
<[CH.Corp.HR.STDLeave@christushealth.org](mailto:CH.Corp.HR.STDLeave@christushealth.org)>  
**Subject:** RE: Liberty Mutual Eligibility Forms – CORP Region (11.28.2017)  
**Importance:** High

Good Morning;

Associate Billy T Green has been Termed 12/16/2016. I did not complete eligibility form.

Thank you,

Yvonne

**From:** Green, Joscelin [<mailto:JOSCELIN.GREEN@LibertyMutual.com>]  
**Sent:** Tuesday, November 28, 2017 6:02 AM  
**To:** !\_CH.Corp.HR.STDLeave <[CH.Corp.HR.STDLeave@christushealth.org](mailto:CH.Corp.HR.STDLeave@christushealth.org)>  
**Cc:** Horton, Terena D. <[terena.horton@christushealth.org](mailto:terena.horton@christushealth.org)>; Herrera, Yvonne  
<[yvonne.herrera2@christushealth.org](mailto:yvonne.herrera2@christushealth.org)>  
**Subject:** Liberty Mutual Eligibility Forms – CORP Region (11.28.2017)

Good Morning,

Please find the eligibility form(s) for the CORP region attached.

Thank You,

L000024

**Joscelin M. Green, AIC**

SBU System Support Analyst II

Liberty Mutual Benefits Technology Services

Liberty Mutual Insurance

P.O. Box 7208, London, KY 40742-7208

Direct Dial: 704-759-7812

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**CONFIDENTIALITY NOTICE:** Confidential information, such as identifiable patient health information or business information, is subject to protection under state and federal law. If you are not the intended recipient of this message, you may not disclose, print, copy or disseminate this information. If you have received this in error, please reply and notify the sender (only) and delete the message. Unauthorized interception of this e-mail is a violation of federal criminal law.

**L000025**



Liberty Life Assurance Company of Boston  
Group Benefits Disability Claims  
P.O. Box 7207  
London, KY 40742-7207  
Phone No.: (800) 291-0112  
Secure Fax No.: (603) 334-7120

December 1, 2017.

Mr. Billy Green

[REDACTED]  
SOPERTON, GA 30457

RE: Short Term Disability (STD) Benefits  
Christus Health  
Claim #: 3908269

Dear Mr. Billy Green:

Liberty Life Assurance Company of Boston ("Liberty") is responsible for managing claims for Short Term Disability (STD) benefits under Christus Health's Group Disability Plan. We are writing in reference to your claim for STD benefits under the Plan.

Based on the information received, your claim has been denied and no benefits are payable.

The Plan contains the following provision regarding termination of coverage:

***WHEN DO STD BENEFIT PAYMENTS END?***

*An STD Program Participant will not be (or will no longer be) eligible to receive STD Benefits on the earliest to occur of the dates set forth below, and, if an STD Program Participant is receiving STD Benefits on account of a Disability on such date, payment of those STD Benefits will stop, or, if an STD Program Participant is scheduled to begin receiving (or continue to receive) STD Benefits on such date, those STD Benefits will not be paid:*

*The date the STD Program Participant terminates employment with CHRISTUS.*

Since your date of disability is December 17, 2016 and you were terminated on December 16, 2016, we are unable to approve your claim.

*Please be advised that you may still be eligible for Long Term Disability Benefits. To determine if you are eligible for these benefits or with questions on next steps, please contact your Case Manager at Liberty Mutual. Liberty Mutual will provide you a time frame that you will need to follow up to file your claim for Long Term Disability benefits if you remain disabled.*

This claim determination reflects an evaluation of the claim facts and the Plan provisions. We

reserve the right to make a determination on any additional information that may be submitted.

Under the Employee Retirement Income Security Act of 1974 (ERISA), you may request a review of this denial by writing to the address below:

The Liberty Life Assurance Company of Boston  
Disability Claims  
P.O. Box 7207  
London, KY 40742-7207

The written request for review must be sent within 180 days from the date of this letter and state the reasons you feel your claim should not have been denied. In your request for review please include the following documentation:

Proof that your employment was not terminated on December 16, 2016.

You should also provide any additional information that you feel will support your claim.

You may request to review pertinent claim file documents upon which the denial of benefits was based. If Liberty Life does not receive your written request for review within 180 days from the date of this notice, our claim decision will be final, your file will remain closed, and no further review will be conducted.

Under normal circumstances, you will be notified of the final decision within 45 days from the date your request is received.

If special circumstances cause a delay in our decision, you will be notified of the final decision no later than 90 days from the date your request is received.

Nothing in this letter should be construed as a waiver of any rights and defenses under the above captioned Plan, and all of these rights and defenses are reserved to the company, whether or not they are specifically mentioned herein.

If you have any questions regarding this matter, please contact me.

Sincerely,

Daniel Hitselberger  
Disabil Claims Case Mgr I  
Phone No.: (800) 291-0112 Ext. 13977  
Secure Fax No.: (603) 334-7120

\*000172\*

31354170058

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON  
GROUP BENEFITS DISABILITY CLAIMS  
P.O. BOX 7207  
LONDON, KY 40742-7207

MR. BILLY GREEN

SOPERTON GA 30457

NIXIE 300 DE 1270 0012/14/17

RETURN TO SENDER  
INSUFFICIENT ADDRESS  
UNABLE TO FORWARD

BC: 40742720707 \*2191-05466-09-00  
|||

\*400000010002000001000172172\*



L000028

CORPUS CHRISTI PAIN MEDICINE  
3825 SOUTH PADRE ISLAND DRIVE  
COPRUS CHRISTI, TX 78415

PH. (361)225-0089 FAX (361)225-0082

**PERMISSION TO RELEASE MEDICAL INFORMATION**

I Billy Green give permission to Corpus Christi Pain Medicine to release  
any medical information in my medical chart to Liberty Mutual

I understand that this information is kept confidential by Corpus Christi Pain Medicine, but by signing  
this release I give my authorization to share such information with

Facility/Physician/Person(s): Liberty Mutual

Phone Number: (800) 291-0112

Fax Number: (603) 334-0380

Patient Signature: Billy T. Green

Patient Date of Birth: [REDACTED]

Printed Name: Billy Green

Date: 11-27-2017

Claim Number:  
3908269

L000029



## Leave Detail

Find	Clear	Save	New	Delete	Last Modified	Print	Help	Amend	Extend	Convert	Chg Sub Loc
------	-------	------	-----	--------	---------------	-------	------	-------	--------	---------	-------------

AS Event AS Link Add Note Associated Leaves Contact Info Coord Claim Note Doc List Document Eligibility Important Info Leave Soft Denial Configuration Live Addtl Info Live Correspondence Live Eligibility Inout

Live Entitlement Live History Live Int Freq Lmt History Live Program Live Time Live Work Sched Note Note Rpt Tasks

Employee: First Name BILLY Last Name GREEN SSN XXX-XX-XXXX DOB MM/DD/YYYY

Customer: Name CHRISTUS HEALTH ID 09 Sub Code TERMD Loc Code TERMDASO

Leave ID 7728458 Previous Leave ID 0 Submitted Via XPRS Leave Sub Code TERM Leave Loc Code TERMDASO Enable Save ☐

## Leave Details

Status	Denied	System Task	LSB
Status Reason	Employment Terminated	Leave Reason	Absence Plus Treatment
Leave Type	Own Disability	Leave Category	Continuous
Coordinated?	Y	Claim Switch	with Claim
Takeover?	N	Prior Carrier ID	3908289
Hospitalized?	Y	WC Clm Num	0
Assign To:	PETTAWAY	CHERYL	

## Related Dates

Begin Date	12/17/2016	End Date	
Request From Date	12/17/2016	Request Thru Date	01/17/2018
Overridden	<input type="checkbox"/>	Overridden	<input checked="" type="checkbox"/>
Certified From Date	12/17/2016	Certified Thru Date	01/17/2018
Misc Form Begin Date		Misc Form End Date	
Received Date	11/27/2017 6:15 PM	Determination Date	11/29/2017
Ext Requested Date		Ext Determination Date	
Last Worked Date	12/16/2016	Closed Date	
Return to Work		Actual RTW Date	
Expected RTW Date		Response Method	
Expected RTW Response			

## Program Entitlement

State	Code	Begin Date	End Date
-------	------	------------	----------

## Intermittent Frequency Schedule

Int Freq Amt	0	Mode	
Freq As Of Date		Reduced Work Schedule	<input type="checkbox"/>

L000030

Leave Entitlement Report									
Find	Clear	Save	New	Delete	Last Modified	Print	Help	Time Applied	
Add Note Document Employee Leave Lve Addtl Info Lve Correspondence Lve Program Lve Time Lve Work Sched Note									
SSN	XXX-XX-XXXX	Employee Name	GREEN, BILLY						
Leave ID	7728458	Customer ID	09	460617	Name	CHRISTUS HEALTH			
Leave Information									
Type	Own Disability	Reason	Absence Plus Treatment			Category	Continuous	Begin Date	12/17/2016
Takeover?	IN	End Date							
Entitlement Calculation									
Entitlement As Of		02/26/2019	Calculate Entitlement		Reported On		02/26/2019 3:20 PM		
Print Report Options									
<input checked="" type="radio"/> Print Directly <input type="radio"/> Save to Disk									
Program Entitlement:									
Leave Program Code	Leave Hours Used	Leave Hours Remaining	Calculation Type	Tracking From	Tracking Thru	Benefit Remaining			

L000031

48108453\_1.txt

Leave Entitlement  
Time Applied Report

No Records Found

**Note Report**

Report	Clear	Print	Help
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[AS Accom](#) [AS Event](#) [Add Note](#) [Appeal](#) [Claim](#) [Coord Claim Note](#) [Correspond](#) [Doc List](#) [Employee](#) [Leave](#) [Life Claim](#) [Lve Addtl Info](#)  
[Lve Correspondence](#) [Lve Program](#) [Lve Work Sched](#) [Medical](#) [Medical History](#) [Note](#) [SPELL Letters](#) [Scheduled Pmt](#) [Task Print](#) [Task Rot](#)  
[Tasks](#)

Claim	Primary Sort Order	Sec
* Claim/Event/Leave Number <input type="text" value="7728458"/>	Note Type	•
Accommodation Number <input type="text"/>	Note Number	
Note type: <input type="text"/>	• Note Date/Time	
	Accm. No.	

**02/15/2019 12:00 PM - PHONE Note 1**

Claim/Event/Leave: 7728458

NoteSubject : EE Called

Other Subject :

Text: [02/15/2019 - MELTON, CHERYL] EE REQUESTED A COPY OF HIS DENIAL LETTER...EMAILED EE PER EE REQUEST..TRANSF ASSISTANCE WITH STD CLAIM

**01/18/2019 12:28 PM - LEAVE Note 5**

Claim/Event/Leave: 7728458

NoteSubject : FMLA

Other Subject :

Text: [01/18/2019 - ALLEN, ANDI] FROM: BILLY GREEN MAILTO:BGREEN99@ATT.NET SENT: TUESDAY, NOVEMBER 28, 2017 8:29 A  
 LMLEAVEADMIN@LIBERTYMUTUAL.COM SUBJECT: FMLA REQUEST 7728458 10/28/2017 BILLY T. GREEN [REDACTED] ST.CORP  
 78418 [REDACTED] BGREEN99@ATT.NET LIBERTY MUTUALLMLEAVEADMIN@LIBERTYMUTUAL.COM DEAR SIR OR MADAM, PLE  
 OF ANY EMAIL OR CORRESPONDENCE REGARDING MY REQUEST FOR FMLA LEAVE FROM NOVEMBER 2016. THANK YOU, BILL'  
 \*\*\*\*\*GOOD AFTERNOON, IF YOU ARE IN NEED OF A NEW FMLA, PLEASE CALL THEINTAKE DEPARTMENT TO  
 AT 877-906-2285 IF YOU HAVE ADDITIONAL QUESTIONS PLEASE CONTACT US AT 1-866-630-9320 OR EMAIL LINCOLNLEAVEADM  
 YOU, ANDI ALLEN SENIOR LEAVE SPECIALIST LINCOLN FINANCIAL GROUP P.O. BOX 7208 LINCOLN, KY 40742 866-630-9320 LINC  
 FOLLOW US ON:

**04/26/2018 11:00 AM - LEAVE Note 4**

Claim/Event/Leave: 7728458

NoteSubject : FMLA

Other Subject :

Text: [04/26/2018 - ALLEN, ANDI] FROM: BROOKS, CATRINA MAILTO:CATRINA.BROOKS2@CHRISTUSHEALTH.ORG SENT: WEDNE  
 10:06 AM TO: LMLEAVEADMIN <LMLEAVEADMIN@LIBERTYMUTUAL.COM> CC: MELLON, ELIZABETH <ELIZABETH.MELLON@CHRI  
 SUBJECT: BILLY GREEN-LEAVE OF ABSENCE IMPORTANCE: HIGH GOOD MORNING, WILL YOU PLEASE FORWARD ANY LEAVE C  
 RELATED TO THE LEAVE CLAIM FOR BILLY GREEN IN 2016. PLEASE SEE THE BELOW. THANKS. CATRINA BROOKS BENEFITS LE  
 \*\*\*\*\*GOOD AFTERNOON, PLEASE SEE ATTACHED. REMEMBER TO VISIT MYLIBERTYCONNECTION.COM FOR IMMEDIATE  
 EMPLOYEES BENEFIT INFORMATION. IF YOU HAVE ADDITIONAL QUESTIONS CALL US AT 866-630-9320, OR EMAIL  
 LMLEAVEADMIN@LIBERTYMUTUAL.COM. REGARDS, ANDI ALLEN SENIOR LEAVE SPECIALIST

**04/25/2018 1:23 PM - LEAVE Note 3**

Claim/Event/Leave: 7728458

NoteSubject : FMLA

Other Subject : LMLEAVEADMIN

Text: [04/25/2018 - SAYABATHA, NETHSANOCK] FROM: BROOKS, CATRINA MAILTO:CATRINA.BROOKS2@CHRISTUSHEALTH.ORG  
 APRIL 25, 2018 10:09 AM TO: SAYABATHA, NETHSANOCK <NETHSANOCK.SAYABATHA@LIBERTYMUTUAL.COM> CC: JACOBS, SC  
 <SOPHIA.JACOBS@CHRISTUSHEALTH.ORG> SUBJECT: FW: BILLY T. GREEN IMPORTANCE: HIGH GOOD MORNING, WILL YOU PI  
 LEAVE CORRESPONDENCE FOR BILLY GREEN? PLEASE SEE THE BELOW EMAIL FROM LEGAL. THANKS.[04/25/2018 - SAYABATH  
 \*\*\*\*\*  
 SAYABATHA, NETHSANOCK SENT: WEDNESDAY, APRIL 25, 2018 1:23 PMTO: 'BROOKS, CATRINA' <CATRINA.BROOKS2@CHRIST  
 'JACOBS, SOPHIA' <SOPHIA.JACOBS@CHRISTUSHEALTH.ORG> SUBJECT: RE: BILLY T. GREEN HELLO, PLEASE SEE ATTACHED  
 TO BILLY GREEN AT BGREEN99@ATT.NET.

**11/29/2017 12:52 PM - LEAVE Note 2**

Claim/Event/Leave: 7728458

NoteSubject : Leave End

Other Subject : SYSTEM GENERATED

Text: THIS LEAVE WAS DENIED FOR EMPLOYMENT TERMINATED

**11/28/2017 7:01 AM - LEAVE Note 1**

Claim/Event/Leave: 7728458

NoteSubject : FMLA

Other Subject : MISSING EE STATE

Other Subject , MISSING EE STATE

Text: [11/28/2017 - FRENCH, JACOB] MISSING EMPLOYMENT STATE TASK - UPDATE EMPLOYMENT STATE TO DOMICILE STATE--

November 29, 2017

**Employee Name:** Mr. BILLY GREEN

**Employer Name:** Christus Health

**Correspondence Type:** Continuous Leave Denial

**Leave ID No.:** 7728458



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- Download forms and educational resources

**First-time users:** Register by creating a user login and password using company code: Christus

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Please contact Liberty Mutual Leave Services if you have any questions.

Sincerely,

DANIEL HITSSELBERGER

Disability Claims Department

Office Phone: (800) 283-0823 Ext. 13977

Office Fax: (603) 334-7120

Attachments: FMLA Rights

CC: Christus Health  
Catrina Brooks  
Yvonne Herrera  
Terena Horton  
Rhonda Holyfield



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**By Phone:** (800) 283-0823

**By Fax:** (603) 334-7120

**Write us:**  
Liberty Life Assurance Company Of  
Boston  
Leave Services  
P.O. Box 8700  
Dover, NH 03821-8700

November 29, 2017

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## Your Rights and Responsibilities Under the FAMILY AND MEDICAL LEAVE ACT

### Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 Weeks of unpaid, job protected leave to "eligible" employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job

### Military Family Leave Entitlement

Eligible employees with a spouse, son, daughter, or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12 month period. A covered servicemember is (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness\*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.\*

\*The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".

### Benefits and Protection:

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

### Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1250 hours over the previous 12 months\*, and if at least 50 employees are employed by the employer within 75 miles.

\*Special hours of service eligibility requirements apply to airline flight crew employees.

### Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirements may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or

incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

### Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatments so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

### Substitution of Paid leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

### Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures. Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

### Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employee's rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

### Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

### Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
WWW.WAGEHOUR.DOL.GOV

WH Publication 1420 Revised February 2013



November 29, 2017

**Employee Name:** Mr. BILLY GREEN

**Employer Name:** Christus Health

**Correspondence Type:** Continuous Leave Denial

**Leave ID No.:** 7728458



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## Purpose of Letter

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**Please note:** You may qualify for a Personal Leave under CHRISTUS' absence policy. If your leave request qualifies for a Personal Leave you will receive additional information from Liberty Mutual regarding this benefit.

Please contact Liberty Mutual Leave Services if you have any questions.

Sincerely,

DANIEL HITSSELBERGER

Disability Claims Department

Office Phone: (800) 283-0823 Ext. 13977

Office Fax: (603) 334-7120

Attachments: FMLA Rights

CC: Christus Health  
Catrina Brooks  
Yvonne Herrera  
Terena Horton  
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**Please note:** You may qualify for a Personal Leave under CHRISTUS' absence policy. If your leave request qualifies for a Personal Leave you will receive additional information from Liberty Mutual regarding this benefit.

Please contact Liberty Mutual Leave Services if you have any questions.

Sincerely,

DANIEL HITSSELBERGER

Disability Claims Department

Office Phone: (800) 283-0823 Ext. 13977

Office Fax: (603) 334-7120

Attachments: FMLA Rights

CC: Christus Health  
Catrina Brooks  
Yvonne Herrera  
Terena Horton  
Rhonda Holyfield



### Receive Letters Sooner

Get letters, forms, and other important information by email! Send your paperless request to [LMLeaveAdmin@LibertyMutual.com](mailto:LMLeaveAdmin@LibertyMutual.com) with your name and leave ID to sign up!



### Contact Us

**By Email:**  
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**By Phone:** (800) 283-0823

**By Fax:** (603) 334-7120

**Write us:**  
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